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No. 92-351

In The

Supreme Court of the United States

October Term, 1992

LEONARD E. HELLER, SECRETARY, KENTUCKY CABINET FOR HUMAN RESOURCES,

Petitioner,

v.

SAMUEL DOE, by his Mother and Next Friend, MARY DOE, et al.,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF OF THE STATES OF NEW JERSEY, INDIANA, MICHIGAN, MINNESOTA, NEBRASKA, SOUTH DAKOTA AND VIRGINIA AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF THE AMICI CURIAE

The state *amici* have a significant and vital interest in providing for care or habilitative services to their mentally ill and mentally retarded residents. The questions posed in this case -- whether hearings requiring proof "beyond a reasonable doubt" are constitutionally mandated prior to institutionalizing mentally retarded persons and whether parents and legal guardians may participate in procedures regarding institutional placement of mentally retarded persons -- are important to the administration of these states' laws relating to these two distinct groups of individuals and to the allocation of limited

resources to provide these services. The states have a strong interest in responding to the disparate needs of these segments of their populations appropriately, and therefore have an interest in showing that differences between these groups can be addressed without violating the Equal Protection Clause.

SUMMARY OF ARGUMENT

The states and federal governments have long recognized fundamental differences between the disabilities and care of mentally ill and mentally retarded persons. The *amici* states assert that the Sixth Circuit's ruling in this case questions the foundations of state statutes which provide for the care of these groups of people, and therefore that ruling potentially undermines the services provided pursuant to those statutes. Specifically, the Sixth Circuit found that mentally retarded persons in Kentucky may not be institutionalized without proof "beyond a reasonable doubt" that institutionalization is required. Application of that standard of review was required under the Equal Protection Clause, because Kentucky employs that standard of review in commitment hearings for mentally ill persons, and the court found no rational basis for differentiating between mentally ill and mentally retarded individuals.

In so ruling, the Sixth Circuit failed to recognize the differences between these two segments of the population, differences which the legislatures of the United States and the several states have long recognized. Given those differences, and the greater invasiveness of the probable treatments and stigmatization that arises from commitments of mentally ill persons, Kentucky's separate procedures provided for placing mentally ill or mentally retarded persons in state facilities are

fully consistent with equal protection guarantees, and the Sixth Circuit's ruling to the contrary should be reversed.

Kentucky's establishment of a hearing process using a "clear and convincing" standard of proof more than adequately protects the constitutional rights of its mentally retarded residents, and no higher standard is constitutionally mandated. In fact, the states have adopted a variety of approaches for providing services to mentally retarded individuals, and states' inherent governmental authority to develop proper approaches should not be limited in the manner suggested by the Sixth Circuit. For example, several states satisfy constitutional requirements not with "commitment hearings" (*i.e.*, hearings prior to committing a person to an institution, a term most commonly used as to mentally ill persons), but rather by having guardians appointed where needed to act in the best interest of mentally retarded individuals for all kinds of decisions, including decisions regarding residence. These alternative approaches, which allow greater respect and dignity for family members while still protecting the rights of the mentally retarded individual, should be considered in reviewing the Sixth Circuit's more restrictive holding.

The *amici* states are understandably concerned that the Sixth Circuit's mandate of hearings using the highest recognized standard of proof places unwarranted additional costs on the State of Kentucky, to the detriment of the mentally retarded individuals who rely on state services. The state *amici* note that, despite federal and state initiatives to rely less on institutions and more on community settings for the mentally retarded, both state and federal dollars are still disproportionately spent on institutions. Requiring additional process for institutional placements may ultimately frustrate

the federal and state goals favoring community settings, and should be rejected by this Court.

ARGUMENT

I. The Equal Protection Clause is Not Violated By Providing Different Hearing Procedures for Mentally Ill and Mentally Retarded Persons, Because There Are Fundamental Distinctions Between These Segments of the Population

The state *amici* provide services for persons with mental retardation and other developmental disabilities,[1]

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[1] "Developmentally disabled" is term which includes but is not limited to mental retardation. It gained national recognition in the Developmentally Disabled Assistance and Bill of Rights Act of 1975, Act of October 4, 1975, Pub. L. No. 94-103, 1975 U.S. CODE CONG. & AD. NEWS (89 Stat.) 486 (codified at 42 U.S.C. § 6000 *et seq.*), where it was said to include disabilities attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions closely related to mental retardation, or dyslexia resulting from any of those disabilities. 1975 U.S. CODE CONG. & AD. NEWS (89 Stat.) 497 (current version codified at 42 U.S.C. §6001(7)(A)(i)). A revised definition in 1978, set forth in Public Law 95-602, 1978 U.S. CODE CONG. & AD. NEWS (92 Stat.) 2955, 3004-05 (amending 42 U.S.C. §6001(7)(A)(i)) changed the focus from named diagnoses to specified limitations in a person's functioning and development. However, the conference report on this amendment specified that this definition "is intended to cover everyone currently covered under the definition and is also intended to add other individuals with similar characteristics." HOUSE CONFERENCE REPT. NO. 95-1780, 95th Cong., 2d Sess. 104-105, *reprinted in* 1978 U.S. CODE CONG. & AD. NEWS 7416. Because the term "mentally retarded" is used in the Kentucky statute and the Sixth Circuit decision under review here, the term "mentally retarded" will be used primarily in this brief, even though some of the state *amici* use the more inclusive "developmentally disabled" term in their statutes.

pursuant to state laws. *See, e.g.*, N.J. STAT. ANN. § 30:6D-23 *et seq.* (West Supp. 1992); MICH. COMP. LAWS ANN. § 330.1116 (West 1980). The United States also has enacted significant legislation regarding mentally retarded persons, but the states continue to have the primary governmental responsibility for providing needed services. Accordingly, the states have an interest in cases such as this which, through interpretation of federal constitutional guarantees, could affect the manner in which the states carry out this important responsibility.

In this case, the state *amici* support Kentucky's argument that the Sixth Circuit erred in the way in which it applied the federal Equal Protection Clause to Kentucky's statute. The Court has stated that "legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest," and that "[w]hen social or economic legislation is at issue, the Equal Protection Clause allows the States wide latitude...." *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985). This general rule gives way to heightened scrutiny where classifications are made by race, alienage, national origin or gender, but the Court has ruled that heightened scrutiny is not warranted where classifications are based upon mental retardation. *Id.*, 473 U.S. at 442-47.

In its equal protection ruling here, the Court of Appeals suggested that it was applying the rational basis test, but instead of presuming that Kentucky's statute was valid, the circuit court held that Kentucky had failed to prove its reasons for the statutory classifications, *Doe v. Cowherd*, 965 F.2d 109, 112 (6th Cir. 1992), thereby turning the presumption of statutory validity on its head. When analyzed properly, Kentucky's position is sound, because there are rational

distinctions between mentally ill and mentally retarded persons for purposes of establishing procedures for placing members of those two groups in state institutions. Kentucky's statute, like many statutes in the states and the United States, recognizes those distinctions and because those distinctions have a rational basis, the Kentucky statute should be upheld as fully consistent with the federal Equal Protection Clause.

A. The Federal Government and Most State Governments Have Historically Recognized Differences Between Mentally Ill and Mentally Retarded Persons

The different needs of mentally ill and mentally retarded persons were highlighted in the early 1960's at the federal level of government, when separate programs were proposed to deal with the needs of these two groups. In a speech to Congress in 1963, then-President Kennedy outlined his goals for legislative initiatives to address the needs of the mentally retarded and mentally ill. President's Message to Congress on Mental Illness and Mental Retardation, 1963 U.S. CODE CONG. & AD. NEWS 1466 (February 5, 1963). These initiatives were presented to Congress at the same time, but as separate program needs with separate appropriation requests. In response to that address, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Act of October 31, 1963, Pub. L. No. 88-164, 1963 U.S. CODE CONG. & AD. NEWS (77 Stat. 282) 309, which provided specific programs for both the mentally ill and the mentally retarded, as distinct groups.

Whether in response to that federal legislation or otherwise, many states have separate statutory provisions

dealing with mentally ill and mentally retarded individuals. In fact, in a large number of states, separate divisions of state government address the needs of these two groups, and services are provided according to separate statutes. *See* 1a. "Mental retardation" has been defined under these statutes as "a significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which are manifested during the developmental period." N.J. STAT. ANN. § 30:4-25.1a(5) (West Supp. 1992); *see also, e.g.*, NEV. REV. STAT. § 433.174 (1991); FLA. STAT. ANN. § 393.063(41) (West Supp. 1992). Definitions for "mental illness" vary more widely in construction, but include "a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, behavior or capacity to recognize reality...." N.J. STAT. ANN. § 30:4-27.2r (West Supp. 1992); *see also, e.g.*, FLA. STAT. ANN. § 394.455(3) (West 1986). Services for the mentally ill therefore focus more on psychiatric treatment and possible remission of illnesses which can enable patients to receive ongoing treatment on an outpatient basis, *see, e.g.*, N.J. STAT. ANN. § 30:4-27.1 (West Supp. 1992); FLA. STAT. ANN. § 394.455(3) (West 1986), while services for persons with mental retardation and other forms of developmental disability primarily focus on education and training to make the most of limitations in mental development which have their onset prior to adulthood. N.J. STAT. ANN. § 30:6D-25(b) (West 1981 and Supp. 1992); ARIZ. REV. STAT. ANN. § 36-554A.1. (Supp. 1992); NEV. REV. STAT. § 433.214 (West 1991).

In 1975, Congress passed the Developmentally Disabled Assistance and Bill of Rights Act of 1975 (hereafter, "Developmentally Disabled Act of 1975"), Act of October 4,

1975, Pub. L. No. 94-103, 1975 U.S. CODE CONG. & AD. NEWS (89 Stat.) 486 (codified at 42 U.S.C. § 6000 *et seq.*), which provided, among other things, for funding to the states conditioned upon their development of a state plan, which plan was required to "support the establishment of community programs as alternatives to institutionalization." *Id.* at (89 Stat.) 491 (formerly codified at 42 U.S.C. § 6062(b)(23); current version at 42 U.S.C. § 6022(b)(C). Accordingly, many states follow that federal legislation in encouraging community living for mentally retarded persons, *e.g.*, N.J. STAT. ANN. § 30:6D-13 (West 1981 and Supp. 1992); MINN. STAT. ANN. § 252.50 (West 1982 and Supp. 1992), which can mean living at home or in other facilities such as supervised apartments or group homes where supervision and assistance in daily living is available. *See, e.g.*, N.J. ADMIN. CODE. TIT. 10, §44A-6 to -7 (1988); MD. HEALTH GEN. CODE ANN. § 7-101(h) (1990); FLA. STAT. ANN. § 393.063(25), (38), (48) (West Supp. 1992).

In addition, however, nearly all of the states do have some institutions, whether operated by the states themselves or licensed by the states, where mentally retarded individuals can be placed for residential care. Significantly, many states provide separate institutions for their mentally ill and their mentally retarded residents. *See, e.g.*, N.Y. MENTAL HYG. LAW § 13.17(b) and § 7.17(b) (McKinney 1988 and Supp. 1992); MINN. STAT. ANN. § 252.025 and § 253.015 (West 1982 and Supp. 1992); WISC. STAT. ANN. § 51.05 and § 51.06 (West 1987 and Supp. 1992). The establishment of separate facilities is not surprising, because the purposes of these two types of institutions are very different. The primary purpose for the state hospitals for the mentally ill is to provide emergency treatment for the mental illness, particularly to deal

with circumstances where because of mental illness, a person is a danger to himself or others. *See*, OHIO REV. CODE ANN. § 5122.01(B) (Page 1989); N.H. REV. STAT. ANN. § 135-C:27 (1990). In contrast, the institutionalization of mentally retarded persons is often based upon the finding that these individuals are unable to care for themselves in the community and require professional staff to meet some or all of their care or education needs.[2] Contrary to the finding of the Sixth Circuit, these differing purposes behind institutional placement support Kentucky's claim that there is a stigmatization associated with mental illness that does not attach to mental retardation.[3]

Numerous state statutes also give credence to Kentucky's argument, rejected by the Sixth Circuit, that services at mental retardation facilities are less "intrusive" than those provided for mentally ill patients. Mental

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[2]For example, in Connecticut, an application to place a mentally retarded person in an institution involuntarily must allege that the person is unable to provide for himself or herself in at least one of the following areas: education, habilitation, care for personal health or mental health needs, meals, clothing, safe shelter or protection from harm. In addition, the application must allege that there is no family member or guardian who can provide adequate care, that the person is unable to obtain care, treatment, education or habilitation without a placement order, and that the person is not willing voluntarily to apply for admission. CONN. GEN. STAT. ANN. §17a-274 (West 1992).

[3]There are situations where a mentally retarded person also suffers from mental illness, and states may have statutes addressing the commitment or transfer of such person to a psychiatric care facility when this mental illness is present. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-280(c) (West 1992).

retardation services are primarily habilitative,[4] with a focus in the statutes on how to improve the mentally retarded person's self-care or self-sufficiency skills. *See, e.g.*, N.J. STAT. ANN. § 30:6D-25f (West 1981 and Supp. 1992); WISC. STAT. ANN. § 51.437(1) (West 1987); WYO. STAT. ANN. § 25-5-102(a)(x) (West 1990 and Supp. 1992). While mentally ill persons may also need improvement in these skills, the primary focus of the statutes for hospitalizing mentally ill persons is "treatment" which has been defined as "care, diagnostic, and therapeutic services including the administration of drugs and any other service for the treatment of an individual." MICH. COMP. LAWS ANN. § 330.1400(e) (West 1980); *see also, e.g.*, WYO. STAT. ANN. § 25-10-101(a)(xiii) (West 1990 and Supp. 1992). These differences in the focus of the services provided at the separate institutions for mentally retarded and mentally ill persons further support Kentucky's argument that the Sixth Circuit's ruling erroneously applied the Equal Protection Clause in this case.

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[4]As this Court noted in *Pennhurst State School v. Halderman*, 451 U.S. 1, 7, n. 2 (1981), "there is a technical difference between 'treatment,' which applies to curable mental illness, and 'habilitation,' which consists of education and training for those, such as the mentally retarded, who are not ill." *See also Youngberg v. Romeo*, 457 U.S. 307, 309, n. 1 (1982)(quoting from the American Psychiatric Association's *amicus* brief: "The word 'habilitation'... is commonly used to refer to programs for the mentally retarded because mental retardation is ... a learning disability and training impairment rather than an illness. [T]he principal focus of habilitation is upon training and development of needed skills."). *See also, e.g.*, ILL. ANN. STAT. ch. 91½, ¶ 1-111 (Smith-Hurd 1987 and Supp. 1992); ME. REV. STAT. ANN. tit. 34-B, § 5461(6) (1988). Nevertheless, the Sixth Circuit here ruled there was a "dispute as to whether mentally retarded persons can be treated so as to improve their condition." 965 F.2d at 112.

B. Kentucky's Use of A Different Standard of Review For Hearings Involving Mentally Retarded Individuals, As Distinguished From Mentally Ill Individuals, Is Appropriate in Light of The Recognized Differences Between Those Groups

The foregoing discussion highlights the significant distinctions which Kentucky, other states and the United States use in establishing laws which relate to mentally retarded and mentally ill persons. The Sixth Circuit recognized that "the mere identification of differences is not enough; equal protection 'require[s] that a distinction made have some relevance to the purpose for which the classification is made.'" *Cowherd, supra*, 965 F.2d at 112, *citing Baxtrom v. Herold*, 383 U.S. 107, 111 (1966). However, because it erroneously disregarded the presumption of statutory validity and rejected Kentucky's claims that the purposes for institutional placement and the presence of stigma are different, that court rejected the differing statutory procedures.

Moreover, the Sixth Circuit relied on *Denton v. Commonwealth*, 383 S.W.2d 681 (Ky. App. 1964), to conclude that the "mentally ill and mentally retarded are identical insofar as they lose their personal liberty by involuntary institutionalization." 965 F.2d at 113. However, this conclusion ignores this Court's ruling in *Addington v. Texas*, 441 U.S. 418 (1979), which held that a "clear and convincing" standard was all that is constitutionally required for the commitment of mentally ill persons. Thus, to the extent that the Sixth Circuit's ruling means that all hearings which may result in a loss of personal liberty require the same standard of proof, this is plainly inconsistent with *Addington*,

where the standard of proof for a loss of liberty arising from a civil commitment for mental illness was permitted to be lower than the standard of proof for a loss of liberty arising from a criminal conviction.

The question then remains whether the mentally ill and mentally retarded can still be considered "identical" insofar as the standard of proof required for their institutionalization, when the overlay of viewing all liberty deprivations the same is lifted. The answer must be no. The Equal Protection Clause analysis focuses on whether similarly situated groups are treated similarly. Here, as discussed above, statutes describe institutions for mentally ill persons as including "treatment" by physicians and more particularly psychiatric professionals. In contrast, the mentally retarded are institutionalized to provide for their everyday care and for education and training toward achieving greater self-sufficiency. Hospitalized mentally ill persons may be asked to reveal thought processes and to express their deepest feelings, *see generally*, THE HARVARD GUIDE TO MODERN PSYCHIATRY 357-491 (A. Nicholi, ed. 1978) and L.D. Handkoff, EMERGENCY PSYCHIATRIC TREATMENT (1969), while the mentally retarded person will focus more on how to accomplish tasks involving everything from personal hygiene to daily employment. *See, e.g.*, N.J. STAT. ANN. § 30:6D-25f (West 1981 and Supp. 1992); ME. REV. STAT. ANN. tit. 34-B, § 5609 (Supp. 1991-92). Kentucky rationally considered the former to be more invasive and stigmatizing, and therefore could rationally determine that something greater than the constitutional minimum set forth in *Addington* was appropriate for committing mentally ill persons, without also believing that this higher standard was needed to protect mentally retarded persons from habilitation in state facilities.

In light of those differences, Kentucky's distinction in the procedures provided for placing mentally ill or mentally retarded persons in a state facility are fully consistent with equal protection guarantees. Similarly, the differences between these two groups constitutionally permit states to provide for other procedural differences, such as Kentucky's statute which allows parents and guardians to participate as parties in hearings involving the mentally retarded, where similar status is not provided to parents and guardians of mentally ill individuals. Accordingly, the Sixth Circuit's holding that Kentucky's statutes violated equal protection is without merit and must be reversed.

II. The Equal Protection Clause Does Not Prevent The States From Using Less Adversarial and Less Costly Means Than Commitment Hearings Using the Highest Standard of Review, and the States Should Be Allowed That Flexibility To Maximize Their Resources for Services to Mentally Retarded Persons

The state *amici* take this opportunity to inform the Court of the many differing approaches states use in providing institutional care for their mentally retarded residents. Many states do not require hearings such as those provided in Kentucky, but instead allow mentally retarded adults or their guardians to apply for voluntarily admission into residential facilities. *See* 2a-4a. This approach shows well-earned respect for families with mentally retarded members. As this Court wrote in *Parham v. J.R.*, 442 U.S. 584 (1979), the law historically recognizes that "natural bonds of affection lead parents to act in the best interests of their children" at 602, and thus, "[t]he statist notion that governmental power should

supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition." *Id.* at 603.

Indeed, facts available regarding institutionalization show that, even among persons with severe mental retardation, for whom disorders such as visual, hearing and speech defects, epilepsy, incontinence and severe behavioral problems may often exist, two out of every three persons with severe retardation are *not* in institutions. Moroney, *Family Care: Toward a Responsive Society*, in ETHICS OF DEALING WITH PERSONS WITH SEVERE HANDICAPS 217, 217-20 (P. Dokecki and R. Zaner eds. 1986). Furthermore, those children who are institutionalized are likely to have the most severe handicaps. *Id.* at 221. This was so in Kentucky, at least at the time of the District Court decision in *Doe v. Austin*, where, of 800 institutionalized mentally retarded persons, 100 were moderately or mildly retarded, 222 were severely retarded and 487 were profoundly retarded. Appendix to Petition, 51a.

In light of these facts, statutes allowing parents or guardians[5] to make residential decisions without requiring a

[5]Guardians here may or may not be family members, although some states which provide for appointment of guardians for the mentally retarded do seek to provide for family members to be appointed as guardians. *See, e.g.*, N.J. ADMIN. CODE tit. 10, § 43-4.1, -7 and -8 (1989); N.H. REV. STAT. ANN. § 171-A:10(II) (1990); MINN STAT. ANN. § 252A.03, Subd. 4 (West Supp. 1992). However, there also may be provisions for appointing a state official with authority in the provision of services for the mentally retarded, when not other appropriate guardian is available. *See, e.g.*, N.J. STAT. ANN. §30:4-165.12 (West 1981 and Supp. 1992); MINN. STAT. ANN. § 252A.03, Subd. 1 (West Supp. 1992). Such statutory schemes are similar to the situation discussed by this Court in *Parham*, where the Court held that the state agency has a duty to consider the best interests of mentally ill children who are wards of the state, and that therefore the State may constitutionally allow the state agency to speak for the child, subject to the restrictions governing natural parents. *Parham, supra*, 442 U.S. at 619.

court hearing, thereby presuming that they act in the best interest of the mentally retarded person, allows appropriate dignity to be accorded to those family members and appointed guardians. A broad rule in this case which would undercut these statutes should be avoided, in light of this Court's statements that states "must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold." *Addington, supra*, 441 U.S. at 430-31 (1979). In addition, this Court has recognized that the mentally retarded are a "large and diversified group," and that statutes dealing with and providing for them "is a difficult and often a technical matter, very much a task for legislators guided by qualified professionals and not by the perhaps ill-informed opinions of the judiciary." *Cleburne, supra*, 473 U.S. at 442-43 (1985) [footnotes omitted]. The Court further wrote that "[e]specially given the wide variation in the abilities and needs of the retarded themselves, governmental bodies must have a certain amount of flexibility and freedom from judicial oversight in shaping and limiting their remedial efforts." *Id.* at 445. In fact, similar needs for state flexibility were present in a case regarding removal of artificial nutrition and hydration, where Justice O'Connor wrote: "Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' or the States [citation omitted] in the first instance." *Cruzan v. Dir., Missouri Dept. of Health*, 110

S.Ct. 2841, 2859 (1990)(O'Connor, J., concurring). While recognizing the approaches used by other states here, this Court should therefore find that the Kentucky statute has addressed these difficult, technical issues in a manner consistent with the Constitution and the Sixth Circuit's decision requiring additional protections should be reversed.

The state *amici* further note that, consistent with federal and state initiatives described previously which seek to rely less on institutions and more on community settings for the mentally retarded, the states have made significant progress in reducing the number of mentally retarded persons in institutions. Between 1977 and 1989, the number of people with developmental disabilities residing in large institutions dropped 42%, to 88,112 people, which is the lowest number since 1934. B. WRIGHT, M. KING AND THE NATIONAL CONFERENCE OF STATE LEGISLATURES TASK FORCE ON DEVELOPMENTAL DISABILITIES, AMERICANS WITH DEVELOPMENTAL DISABILITIES: POLICY DIRECTIONS FOR THE STATES 21 (1991). Indeed, New Hampshire has become the first state to close all of its institutions for persons with developmental disabilities. *Ibid.* Nevertheless, nationally state and federal dollars are still disproportionately spent on institutions. In 1988, state and local governments spent $4.2 billion on community care and $2.7 billion on institutional care, even though about 90% of persons with developmental disabilities live in the community. B. WRIGHT, WHAT LEGISLATORS NEED TO KNOW ABOUT MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES 3 (1990). This means that states spent close to 40% of their resources on 10% of their clients. *Ibid.* The addition of further procedures prior to placing mentally retarded persons in institutions will continue to skew the allocation of state

monies toward institutional care, in conflict with the federal and state policies favoring community care.

Furthermore, this Court has recognized in *Parham* that increasing procedures prior to hospitalizing mentally ill children would mean that mental health professionals would spend increased time traveling to, waiting for and participating in hearings, instead of spending that time caring for patients. *Parham, supra,* at 606. Requiring further hearings using higher standards of proof for institutional placements of mentally retarded persons will similarly divert professionals from their care and habilitative functions, and the cost of these additional procedures and professionals' time will necessarily come from the budgets for services for the mentally retarded.

It is worth noting two additional procedures used by states which help ensure appropriate protections for the mentally retarded. First, some states require regular reevaluations of the appropriateness of the mentally retarded person's placement in the institution, even where the placement is the result of a voluntary admission. *See, e.g.*, MICH COMP. LAWS ANN. § 330.1510 (West 1980); MD. HEALTH GEN. CODE ANN. § 7-505 (1990); KAN. STAT. ANN. § 76-12b05 (1989). Second, in the Developmentally Disabled Act of 1975, Congress conditioned the payment of certain funds to the states upon their establishment of a system of advocacy and protection for the developmentally disabled. 42 U.S.C. § 6012. Many states have followed through on establishing such advocacy and protection agencies. *See, e.g.*, N.J. STAT. ANN. § 52:27E-41.1 *et seq.* (West 1981); ILL. ANN. STAT. ch. 91½, ¶ 1-1150 *et seq.* (Smith-Hurd 1987 and Supp. 1992); N.Y. MENTAL HYG. LAW § 47.01 (McKinney 1988); MASS. GEN. LAWS ANN. ch. 19C, § 2 (Supp. 1992). In light of these additional protections provided by states, the

universal requirement of hearings using a beyond a reasonable doubt standard is certainly unwarranted.

Of course, some states -- now including Kentucky as a result of the Sixth Circuit's decision in *Doe v. Austin*, 848 F.2d 1386 (6th Cir. 1988), *cert. denied sub nom Cowherd v. Doe*, 488 U.S. 967 (1988) -- have provided for and budgeted for hearings prior to placing mentally retarded persons in institutions. For the most part, these states provide for using a "clear and convincing" standard at those hearings.[6] Where those states have used the same standard for commitment of mentally ill persons as *Addington* permits, the Sixth Circuit's equal protection analysis clearly would not invalidate those statutes. However, in light of the invasiveness of the probable treatments and the potential stigma of commitments of mentally ill persons, Kentucky can certainly show rational reasons for requiring a standard of proof beyond the constitutional minimum before committing mentally ill persons, without exceeding the constitutional minimum where mentally retarded individuals are being placed in institutions for their care and habilitation. Because it failed to recognize

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[6]Like Kentucky, Michigan also uses different standards of review for hearings which it provides for mentally ill and mentally retarded individuals. In commitment hearings for the mentally ill in Michigan the "clear and convincing" standard approved by this Court in *Addington* is used, MICH. COMP. LAWS ANN. § 330.1465 (West 1980), while in hearings to admit mentally retarded persons involuntarily, the traditional preponderance standard is used. However, Michigan does use the "clear and convincing" standard for appointment of guardians for the mentally retarded, and does not permit a guardian to place such person in a "facility" without court approval. MICH. COMP. LAWS ANN. § 330.1623 (West 1980). "Facility" in this statute includes both institutions and community residential programs. MICH. COMP. LAWS ANN. § 330.1600 (West 1980).

these legitimate policy distinctions, the Sixth Circuit's decision here found a violation of the Equal Protection Clause where none exists, and should be reversed by this Court.

CONCLUSION

For all of the foregoing reasons, the judgment of the Sixth Circuit should be reversed.

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APPENDIX

I. State Laws Which Establish Separate Governmental Agencies For Mental Retardation Or Developmental Disabilities Services

ARK. STAT. ANN. § 20-48-202,-210 (1991)

ARIZ. REV. STAT. ANN. § 36-551(15) (Supp. 1992)

CAL. WELF. & INST. CODE § 4400 (West. 1984)

CONN. GEN. STAT. ANN. § 17a-210 (West 1992)

DEL. CODE ANN. tit. 29, § 7909A (1991)

ME. REV. STAT. ANN. tit. 34-B, § 5201 (Supp. 1991-92)

MD. HEALTH GEN. CODE ANN. § 7-201 (1990)

MASS. GEN. LAWS ANN. ch. 19B, § 1 (West Supp. 1992)

N.H. REV. STAT. ANN. § 135-C:6(II) (1990)

N.J. STAT. ANN. § 30:6D-24 (West Supp. 1992)

N.Y. MENTAL HYG. LAW § 13.01 (McKinney 1988)

OHIO REV. CODE ANN. § 5123.02 (Page 1989 and Supp. 1991)

S.C. CODE ANN. § 44-20-30(7) (Law. Co-op. Supp. 1991)

II. State Laws Which Allow For Admission of Mentally Retarded Persons into Residential Facilities Without Prior Hearings

ALA. CODE. § 22-52-51 (1990)

ARK. STAT. ANN. § 20-48-405, -406 (1991)

ARIZ. REV. STAT. ANN. § 36-560 (1986)

CONN. GEN. STAT. ANN. § 17a-281 (West 1992)

FLA. STAT. ANN. § 393.065 and § 393.0651 (West Supp. 1992)

HAWAII REV. STAT. § 333F-9 (1991)

IDAHO CODE § 66-408-410 (1989)

ILL. ANN. STAT. ch. 91½, ¶ 3-401 (Smith-Hurd 1987 and Supp. 1992)

IOWA CODE ANN. § 222.13 (West 1985)

KAN. STAT. ANN. § 76-12b02 (1989)

ME. REV. STAT. ANN. tit. 34-B, § 5473 (Supp. 1991-92)

MD. HEALTH GEN. CODE ANN. § 7-505 (1990)[1]

MASS. GEN. LAWS ANN. ch. 123B, § 6 (West Supp. 1992)

MICH COMP. LAWS ANN. § 330.1509 (West 1980)

MISS. CODE ANN. § 41-19-207, -239 (Supp. 1992)

MINN. STAT. ANN. § 252.025 (West 1982 and Supp. 1992)

NEB. REV. STAT. § 83-383 (1987 and Supp. 1992)

NEV. REV. STAT. ANN. § 435.122 (1991)

N.H. REV. STAT. ANN. § 171-A:5 (1990)

N.J. STAT. ANN. § 30:4-25.1b (West Supp. 1992)

N.M. STAT. ANN. § 43-1-14 (1989)

N.Y. MENTAL HYG. LAW § 13.17(b) and § 7.17(b) (McKinney 1988 and Supp. 1992); N.Y. ADMIN. CODE tit. 14A, §§ 15.1-15.5 (1988)

N.C. GEN. STAT. § 122C-241 (1989 and Supp. 1992)

OHIO REV. CODE ANN. § 5123.69 (Page 1989)

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[1]Within 21 days of voluntary admission, a hearing officer of the Department must hold a hearing to determine by clear and convincing evidence that the admission was appropriate. § 7-503.

PA. STAT. ANN. tit. 50, §§ 4402-4404 (Purdon 1969 and Supp. 1992)

R.I. GEN. LAWS § 40.1-21-6.1 (1991)

S.C. CODE ANN. § 44-20-440 (Law. Co-op. Supp. 1991)

S.D. CODIFIED LAWS ANN. § 27B-5-2 (1992)

TENN. CODE. ANN. § 33-5-101 (Supp. 1992)

TEX. HEALTH & SAFETY CODE ANN. § 593.022 (1992)

W. VA. CODE § 27-4-1 (1992)

WISC. STAT. ANN. § 51.10 (West 1987 and Supp. 1992)

WYO. STAT. ANN. § 25-5-117 (West Supp. 1992)